CERTIFICATION OF HEALTH CARE PROVIDER FOR LIGHT DUTY ASSIGNMENT

This form should be submitted by any employee requesting a temporary light duty assignment because of temporary job restrictions due to a **non-work related** injury or illness. If the employee's job restrictions are permanent and a permanent accommodation is needed, the employee should make a request for such an accommodation to the City's Commissioner on the Disabled.

Section 1		To be completed by the employee		
1.	Name:			
	employee	essification:e must provide their health care page with this form.)	provider with a copy of the em	ployee's job
Employee Signature			Date	
Secti	ion II	To be completed by the employe	ee's health care provider	
	ical limitat	list any work restrictions of this tions and the tasks or job function libe unable to perform):	* · ·	•
2. restri	Please ictions:	describe the medical condition	(s) that necessitates this emp	
3.	Date w	ork restrictions commenced or w	vill commence:	
4. vour	•	ou anticipate that the employed		d (please use

5. Are you treating, or overseeing the treatment condition that necessitates the employee's work results.					
6. Date of employee's next scheduled visit wi	th you:				
GINA DISCLAI	<u>IMER</u>				
Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b)					
Signature of Health Care Provider	Date				
Printed Name of Health Care Provider:					
Type of Practice:					
Address:					
Phone Number:					
(01/21/2020)					